STATE OF MICHIGAN
IN THE SUPREME COURT

Appeal from Ingham County Circuit Court, Lower Court No. 98-88770-CZ, Honorable Michael G. Harrison

BLAKEWOODS SURGERY CENTER, L.L.C. JACKSON MEDICAL SERVICES, INC., PAUL ERNEST, M.D., KEVIN LAVERY, M.D., ANTHONY SENSOLI, M.D., SIGMUND ANCEREWICZ, M.D., KHAWAJA IKRAM, D.O., SHARON ROONEY-GANDY, D.D., ARTHUR WIERENGA, M.D., MARTIN PATRIAS, M.D., MICHAEL CHAMES, M.D., GHULUM DASTGIR, M.D., AND KABINDRA MISHRA, M.D.,

Plaintiffs-Appellants,

S.C. No. 118935
C.O.A. No. 221494
Lower Ct. No. 98-88770-CZ

v.

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES, in his official capacity.

Defendant-Appellee.

/

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ORAL ARGUMENT REQUESTED

PLAINTIFFS-APPELLANTS' BRIEF IN REPLY ON APPEAL TO BLUE CROSS/BLUE SHIELD'S AMICUS CURIAE BRIEF AND PROOF OF SERVICE

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For their Reply to Blue Cross and Blue Shield of Michigan's (hereinafter, "BCBSM") Amicus Curiae Brief, Plaintiffs-Appellants Blakewoods, et al., (hereinafter, "Appellants"), submit the following.

BCBSM argues against Appellants' position in this matter based on two assertions: (1) That the interpretation of the statute and delegation of legislative power is rightfully adjudicated *via* the provider class plan (PCP) review provided for in *Part 5 of 1980 PA 350*, through the continuing appeal of each successive, remedial or modified BCBSM, PCP; and, (2) that the doctrine of "primary jurisdiction" should control and thus, prohibit the Court from assuming jurisdiction over the question of law that is presented in this matter.

Appellants incorporate by reference their Brief on Appeal in the instant matter and submit that BCBSM's arguments are without merit. As this honorable Court has indicated through its question to the Appellee Commissioner (IC) in its Order, dated 10/23/2001, this matter turns on the statutory language in *MCL 550.1502(8)* that provides:

> A health care corporation shall not deny participation to a freestanding surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities, is licensed under part 208 of the public health code, 1978 PA 368, MCL 333.20801 to 333.20821, and complies with part 222 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260.

Referencing this language, this Court's Ordered the IC to answer whether permitting BCBSM to use "Evidence of Need" (EON) determinations is a "reasonable standard" to deny participation status (and, therefore, reimbursement for services) to ambulatory surgery facilities. This is a question of law; therefore, it is within the province of the Court.

The instant action is an appeal from an action brought under *MCL 550.1619(3);* there is no jurisdiction to hear this matter under *Part 5 of 1980 PA 350*; no decision resulting from an

attempt to decide the matter under *Part 5* can be said to flow from "competent jurisdiction". Were such a review permitted, the IC could review his own failure to enforce *Part 6* of the *Act*.

The *Part 5* PCP review is statutorily limited, not intended as a vehicle for statutory interpretation beyond its specific charge—the review of a "reimbursement arrangement". That Review is confined to determining whether or not BCBSM's PCP achieved or reasonably failed to achieve the statutorily-defined goals of "cost", "quality" and "access". An IHO who hears an appeal of the IC's Determination and Order pursuant to a PCP review may only affirm or reverse the IC's determination as to whether the Plan is retained or whether a remedial Plan must be filed. *Part 1* of the *Act* defines "PCP" and "reimbursement arrangement", as follows.

> *MCL 550.1108 (1)* "Reimbursement arrangement" means policies, practices, and *methods by which a health care corporation makes payments to a provider* to implement the provider class plan. *Emphasis added.*
>
> *MCL 550.1107 (7)* "Provider class plan" means a document containing a *reimbursement arrangement and objectives for a provider class*, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract. *Emphasis added.*

According to the *Act*, a reimbursement arrangement is a means of making payments to a provider, not a means of determining who or what will be recognized as a provider. The reimbursement arrangement is supposed to be implemented in a manner that can achieve the goals in *Section 504* of the *Act*.

MCL 550.1509 (1) provides for the provider class plan review as follows:

The commissioner may determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan...

MCL 550.1504 (1) provides:

A health care corporation shall, with respect to providers contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:

(a) There will be an appropriate number of providers throughout this *state to assure the availability* of certificate-covered health care services to each subscriber.

Emphasis added.

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

The PCP review is limited to consideration of these statutorily defined items. It cannot be expanded to make medical licensure "need" determinations, particularly since the IC has no authority over medical provider "need". Medical licensure "need" criteria may not be prescribed in the *Insurance Code* or *General Insurance Laws* to interfere with, override or amend the *Public Health Code* wherein the Legislature has delegated its authority to govern medical provider licensure, including "need" determination. *MCL 550.1502(8) correctly recognizes this, prescribing the standard for provider "need" to be applied, citing the Public Health Code. MCL 555.1515(3)* limits the relief that can be obtained on appeal, regarding a PCP, as follows:

(3) In an appeal pursuant to this section, the relief available to a person, and the decision of an independent hearing officer hearing an appeal, shall be limited to the following:

(a) Affirming or reversing a determination of the commissioner under sections 509(1) and 510(1).

(b) Determining, based on the information and factors described in section 504(4) and the standards prescribed in section 516, 1 of the following:

(i) That the provider class plan prepared by the corporation under section 511(1) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(ii) That the provider class plan prepared b the commissioner under section 513(2)(a) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(iii) That a provider class plan described in subparagraph (i) or (ii) was not prepared in compliance with sections 511(1) or 513((2)(a), respectively, and shall not be retained as provided in section 506(4). In this case, the hearing officer shall order the corporation to prepare and submit a provider class plan as provided in subsection (4). Detailed findings must accompany the determination made by the hearing officer pursuant to this subdivision.

Thus, the PCP review is strictly limited to the review of a reimbursement arrangement regarding statutorily defined "goals" and the relief available in an appeal of the outcome of that review

before an IHO is limited to either affirming or reversing the IC's decision to retain the plan or to require a remedial plan. Therefore, any appeal of that decision is necessarily limited to determining whether the IHO's decision to affirm or reverse the IC's retention or refusal to retain the plan. The Court in *In re Medical Doctor Provider Class Plan, 203 Mich App 707, 729-731; 514 NW2d 471 (1994)* speaks to the deference that the IHO must give to the IC's determination because of the considerable expertise required. The IC cannot claim any expertise with regard to medical provider "need" determination, since that authority has not been delegated to the IC; but resides in the Department of Community Health, pursuant to the provisions of the *Public Health Code*. The *Medical Doctor Provider Class Plan* Court also stated that the IC's determination "should not be disturbed unless it is so clearly wrong that it is equivalent to the extreme of a confiscatory or oppressive rate", stating that the IHO could not substitute his or her judgment for that of the IC's. Finally, that Court found that the IHO may only affirm or reverse the determination of the IC. This limited review does not include interpretation of statutes that deal with the determination of medical provider "need" or questions of the relationship of the *Act* to other regulatory statutes outside the *Insurance Code* and *General Insurance Laws*. The Court interpreted the PCP review to be a means of assessing reimbursement —not a means of determining whether or not to recognize a provider's state license. *See pp 48-50, & 54-57, Appellants' Brief on Appeal* in the instant matter that discusses the prohibitions against using legislative powers that have not been delegated and the invalidity of delegations that are non-specific, lack required standards or violate constitutional provisions. The IC should have exercised his powers under *Part 6* of the *Act* to prohibit BCBSM's *ultra vires* use of EON.

If the PCP was a remedy, it was not available to Appellants. *MCL 550.1509(7)* provides only that the IC must conduct enough PCP reviews in each 3-year period to account for 75% of

the health care corporation's payout. (If the hospital plan is reviewed regularly (as it is) few other plans must be addressed.) There is no requirement to review any given PCP and no means is provided for a provider to use to initiate such a review.

Two additional "remedial" plans have been filed since the IC's Determination and Order on the BCBSM Ambulatory Surgery Facility PCP—these have been included in the extensive "Appendix" that BCBSM has included following its Amicus Curiae Brief. The entire appeal process for the *Part 5* PCP review has become quite baffling. The IC has taken the position that each time BCBSM files a new PCP modification or new remedial plan, the appeal process begins anew and all of the issues raised or orders issued on any previously file versions of the Plan become "moot". This finding is made when BCBSM and the IC disagree with the Order of an IHO. When the IC and BCBSM wish to carry forward a plan provision that is being challenged, the IC finds that previous rulings on former Plans bar further litigation under the principle of *res judicata*. Contrary to statute, the process is now something of an "endless loop".

It is painfully obvious that issues of law must remain, as the constitution provides, the province of the Court. *See Exhibit 1, attached, the IC's latest order regarding "appeals" of the last remedial plan that opens the door to BCBSM filing yet another modified Plan by 4/1/03—thus continuing the process with no means of appeal and establishes another "appeal" process outside the statute (Item 4, p8 of the order) and see IC's support for non-conforming order arguing that issues raised pursuant to a plan are "moot" once a modification is filed—this order was so flawed that it was nearly impossible to discern its meaning. The Order was in response to Vision Institute's attempt to appeal the IC's Order regarding the remedial BCBSM Ambulatory Surgery Facility Provider Class Plan—the IHO references some matter argued in 1968?, an unknown "subsequent case", unknown "previous cases" and an agreement on "identical"*

issues, dismissing the appeal based on res judicata. Petitioners objected to this Order, but were refused further proceedings or clarification.

See also letters from the IC's legal counsel stating that previous IHO orders dealing with earlier versions of a Plan do not apply, once a new version of a plan is filed. These letters address the BCBSM Physical Therapy Provider Class Plan appealed before an IHO—though an appeal was filed by BCBSM and the IC, at that time, no Motion had been filed or granted to stay the IHO's Order. See MCL 24.304 (1). These are a few examples of the extreme confusion resulting from attempting to use the PCP review for matters beyond its scope.

BCBSM argues that Blakewoods has attempted an "end run" around the administrative process. BCBSM is confused. In the instant matter, the IC agreed to conduct a PCP review only after the Circuit Court had a request for summary disposition before it that would have decided the pertinent issues in the case. *See Appellants' Appendix, p 370a, lines 5-20.*

Finally, this argument ignores *Part 6 of the Act. Sec. 619(3)* provides that any person (including a provider) can bring an action before the Ingham County Circuit Court to compel the IC to enforce the *Act. Part 6* also provides that the IC must "regulate and supervise" *(Sec. 601)* BCBSM and provides that if the IC knows that BCBSM is violating any statute, he must take steps to stop this and is given the tools to accomplish this. *See Sec.'s 603 and 605 of the Act. Part 6* of the *Act* is not superfluous, but is the Legislature's means of guaranteeing protections for the public and those directly affected by the potential for the health care corporation's misconduct. The *Part 5* PCP review process was never intended to permit BCBSM to violate the law; its *ultra vires* activity and its unlawful and discriminatory violations of the rights of others are not protected with a cloak of immunity pursuant to the provisions of *Part 5,* a narrowly-drawn process to determine if reimbursement levels and methods of payment are effective in

assisting BCBSM to reach the prescribed goals of cost, access and quality—nothing more. There was no requirement to pursue an administrative remedy in the instant matter—no administrative remedy was available. **Under the provisions of the PCP review process, the IC has no jurisdiction to make a statutory interpretation regarding medical provider "need".**

BCBSM implies that the primary jurisdiction doctrine controls in the instant matter. It does not apply. This doctrine suspends court action on an issue (that is cognizable in the court) when the resolution of pertinent issues under a regulatory scheme have been placed within the special competence of an administrative body. There is no fixed formula for applying this doctrine. The Court in *Rinaldo's Construction Corp v Michigan Bell Telephone Co. 454 Mich 65; 559 NW2d 647 (1997),* considering whether to apply the doctrine, found that a court must first determine:

> the extent to which the agency's special expertise makes it a preferable forum for resolving the issue; (2) the need for uniform resolution of the issue; and (3) the potential that the Court's resolution of the issue will have an adverse impact on the agency's performance of its regulatory responsibilities.

In *Rinaldo*, the question arose because the plaintiff had pled a claim in tort stemming from the Defendant telephone company's negligent manner of providing service. While, the Court did not deny that the appropriate jurisdiction for a tort claim was that of the Court, it found that the agency, using its specialized expertise pursuant to the relevant regulatory statute, could resolve the issues raised by the Defendant's complaints about the telephone company's conduct. Thus, the *Rinaldo* Court determined that it must recognize the agency's primary jurisdiction.

Here the situation is reversed. The instant matter does not concern a claim in tort stemming from BCBSM's failure to carry out its reimbursement arrangement as provided for by statute. The instant matter does not require the agency's expertise—quite the contrary. Throughout the myriad of PCP reviews, challenges and appeals, the IC has steadfastly refused to

prohibit BCBSM from acting in an *ultra vires* manner by using its own "evidence of need" determination to refuse to recognize Blakewoods' licensure. *See BCBSM's Amicus Curiae Brief's Appendix—all provider class plan revisions that* ***all include EON determinations***. The IC has no licensure authority and possesses no expertise in provider "need" determination or in fashioning medical provider licensure criteria. He has no authority over medical providers. The Legislature has delegated its constitutionally vested authority to regulate medical provider licensure in the *Public Health Code*—not in the *Insurance Code* or in the *General Insurance Laws*. The Legislature made this clear in *Sec. 502(8)* of *1980 PA 350* by referencing the statutory provisions in the *Public Health Code* that provide for licensure of ambulatory surgery facilities and the required certificate of need. Neither the IC nor BCBSM may ignore the plainly stated legislatively prescribed criteria, by replacing it with BCBSM's evidence of need determination. (They cannot even do this by including it in a provider class plan.) The central issue in the instant matter hinges on interpretation of the law. It has nothing to do with the IC's duties or expertise—other than his duty under *Part 6* to stop BCBSM from engaging in *ultra vires* acts. Uniformity can only be gained by permitting the Court to finally interpret the statute. Otherwise Blakewoods, other ambulatory surgery facilities, and the public will continue to be faced with the difficulties that stem from two different entities—the Community Health Department and BCBSM—making determinations as to whether or not a surgery facility meets licensure criteria and may offer professional (for payment) outpatient surgical services. The reasoning in *Rinaldo, supra*, makes it clear that this is not a case for the application of the Primary Jurisdiction Doctrine. In fact, given the "endless loop" of the PCP process, returning this matter to the IC nearly guarantees that it will never be resolved.

BCBSM overlooks the fact that this honorable Court is cognizant of the issues surrounding the IC's authority and jurisdictional claims. This is evidenced by the Court's Order dated 10/23/01, and its subsequent grant of Blakewood's application for leave to appeal.

BCBS cannot deny its violation of its enabling *Act* while it uses *ultra vires* means, *via* its EON, to actively force outpatient surgery services to be rendered in the highest cost setting—cost-based outpatient hospital units where facility fees are 30%-50% higher than those at physician-owned facilities such as Blakewoods. Under BCBSM's reimbursement arrangements with hospitals, the more the hospital's services cost, the higher BCBSM's reimbursement per service. Physician-owned freestanding ambulatory surgery facilities, such as Blakewoods are reimbursed by BCBSM at a flat rate from a fixed fee schedule—the cost is lower and can be controlled. The *Act* provides that BCBSM must fashion reimbursement arrangements to control costs; yet it consistently fights to eliminate all lower cost providers.

When BCBSM experiences an adverse Order in the course of the PCP review process, BCBSM simply refuses to implement the Order. If BCBSM fears that an IHO's ruling may be adverse, BCBSM files and holds a "modified" PCP, implementing it only if it is necessary to avoid the IHO'[s Order. The IC sanctions these actions even though the "modified" PCP contains the the same offending provisions as the one ruled against, claiming that a newly revised PCP cannot be reviewed for at least another 3 years. *See Exhibit 2, attached, letters to providers' counsel from IC's counsel re: IHO Order.*

The Court in *BCBSM v Milliken 422 Mich 1 ; 367 NW2d 1 (1985)* stated that the Legislature intended that *1980 PA 350* would eliminate BCBSM's tendency to favor certain providers, citing the symbiotic relationship that BCBSM maintained with them to the detriment of the public. It cited the unnecessary escalation in costs that had been the result of these alliances. The *Millliken*

Court cited *Regulation Through the Looking Glass, by Payton and Powsner, 79 Mich Law Review 203, (pp 33a-106aAppellants' Appendix)* which explains the results of BCBSM's alliances with hospitals and the negative effects of vertical integration of services in the hospitals. The significance of the issues raised in this matter reaches beyond the interests of Blakewoods, surgery facilities in general, and BCBSM. These issues impact on the cost and availability of quality health care for the citizens of Michigan, on the validity of our constitutional separation of powers, and the public and private right to rely on valid determinations regarding medical licensure and the application of regulatory law in the public interest and for the public good. Permitting BCBSM to act in a manner that is above the law, not subject to review by any other entity, as if it were a fourth branch of government, has not resulted in protecting the public interest. Our runaway health care costs have been widely publicized. Nearly every business in the state has been seriously affected by the exponential rise in these costs over the past two decades.

WHEREFORE, Appellants Blakewoods, et al. respectfully request that this honorable Court reject the incorrect and unsupported reasoning in BCBSM's Amicus Curiae Brief and issue its Opinion in accordance with Blakewood's request for relief in its Appeal Brief in the instant matter.

Respectfully submitted,

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STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
BUREAU OF HEARINGS
Michael Zimmer, Director

In the matter of:	Docket No. 2001-680
Vision Institute of Michigan Surgery Center, PC, Laurence Loewenthal, MD, and Jay Novetsky, MD,	Agency No. 01-286-BC
	Agency: Office of Financial & Insurance Services
Petitioners,	Case Type: Appeal Subscriber/Provider
v	
Frank M. Fitzgerald, Commissioner of the Office of Financial & Insurance Services, in his official capacity,	**ORAL ARGUMENT REQUESTED**
Respondent. _____/	

RESPONDENT'S BRIEF IN OPPOSITION TO "PETITIONERS MOTION OBJECTION TO ORDER FOR DISMISSAL BASED, IN PART, ON NON-COMPLIANCE WITH MCL 550.1515 AND MCL 24.285, AND REQUEST FOR REHEARING/RECONSIDERATION AND REQUEST FOR ADDITIONAL FINDINGS DUE TO MISREPRESENTATIONS RELIED UPON BY THE RESPONDENT AND THE TRIBUNAL"

Introduction

The Petitioners' Motion should be rejected for at least six reasons:

1. The Petitioners' Appeal is moot.

2. The Petitioners have failed to set forth any statutory or case law which allows the filing of such motion subsequent to the issuance of a decision by an Independent Hearing Officer.

3. The Petitioners have failed to set forth any palpable error made by the Independent Hearing Officer which would justify the granting of a motion for rehearing.

4. The Petitioners have failed to support their factual allegations with any admissible evidence.

5. The case of *Blakewoods Surgery Center LLC, et al v Michigan Insurance Commissioner*, Supreme Court Docket No. 118935 is not applicable to this matter.

6. The Independent Hearing Officer's decision does not violate MCL 24.285.

Thus, the Independent Hearing Officer should deny the Petitioners' Motion.

Statement of Facts[1]

On March 30, 2000, the Respondent Commissioner (hereafter Commissioner) issued his "Order Issuing Determination Report," as provided by MCL 550.1509, with regard to the Ambulatory Surgical Facilities Provider Class Plan. Pursuant to MCL 550.1510(1)(c) the Commissioner concluded that, while Blue Cross Blue Shield of Michigan (hereafter BCBSM) did meet the cost goal found in MCL 550.1504(1)(c), it failed to meet the access and quality of care goals. As a result, pursuant to MCL 550.1510(2) and MCL 550.1511(1) BCBSM was required to submit a Remedial Ambulatory Surgical Facilities Provider Class Plan that "substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the Commissioner."

On May 1, 2000, the Petitioners filed an appeal of the Commissioner's March 30, 2000, Order as provided in MCL 550.1515(1). In an Order dated November 29, 2000, Independent Hearing Officer James K. Nichols affirmed the Commissioner's Order of March 30, 2000, finding that the Commissioner properly concluded that BCBSM could have reasonable Evidence of Needs standards applicable to all ambulatory surgery facilities that wanted to participate with BCBSM. (See Respondent's Exhibit 3, pp. 4-5, ¶ 15-18.)[2]

On December 29, 2000, BCBSM filed its Remedial Ambulatory Surgical Facilities Provider Class Plan. On March 29, 2001, the Commissioner issued his decision that this plan

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[1] The Commissioner previously set forth detailed Statement of Facts in his Briefs of June 22, 2001, July 12, 2001 and July 27, 2001.

[2] Respondent's exhibits 1 through 5 were filed with his Motion for Summary Disposition dated June 22, 2001.

substantially achieved the goals and objectives and substantially overcame the deficiencies enumerated in the findings which he had made in his March 30, 2000, Order. As a result, the Commissioner retained the plan submitted by BCBSM on December 29, 2000. (See Petitioners' Exhibit 1, p. 8, filed with their Petition on April 30, 2001.)

The Petitioners' appeal of the Commissioner's Order of March 29, 2001 raised substantially the same issues that the Petitioners had raised in the Ingham County Circuit Court case in entitled *Vision Institute of Michigan, et al v BCBSM and Commissioner*, Ingham County Circuit Court Docket No. 98-089017-CZ. The Ingham County Circuit Court dismissed the Petitioners Complaint and the Court of Appeals affirmed in an unpublished opinion dated July 17, 2001, Docket No. 217541. (Petitioners Motion, Exhibit 2.) The appeal filed by the Petitioners also raised substantially the same issues which the Petitioners had raised in their administrative appeal of the Commissioner's Order of March 30, 2000, entitled *Blakewoods Surgery Center and Vision Institute(Surgery Center of Michigan), et al v Frank M. Fitzgerald*, Insurance Bureau Docket No. 20001023 which Independent Hearing Officer Nichols dismissed by Order dated November 29, 2000. The core issue in each of these cases was the Petitioners' challenge to BCBSM's authority to utilize Evidence of Necessity or Evidence of Needs standards as a condition of participation with an ambulatory surgery facility.

On June 22, 2001, the Commissioner filed a Motion for Summary Disposition with Brief in Support of the Petitioners' appeal of his March 29, 2001, Order. On that same date, the Petitioners filed a Motion for Preemptory Reversal and/or Summary Disposition. On July 13, 2001, the Economic Alliance for Michigan filed an Amicus Brief. Oral argument was held on the various motions on August 6, 2001. In an Order dated January 24, 2002, Independent Hearing Officer John P. O'Brien dismissed the Petition for Appeal and Motion filed by the Petitioners because he found that the issues raised were identical to those previously raised in the

Circuit Court and before Independent Hearing Officer Nichols. Independent Hearing Officer O'Brien reached this conclusion based upon the doctrine of res judicata.

On December 12, 2001, BCBSM submitted modifications to its Ambulatory Surgical Facilities Provider Class Plan. In an Order dated January 31, 2002, the Commissioner approved those modifications. (Respondent's Exhibit 6.)

On February 7, 2002, the Petitioners filed the instant Motion. Following is the Commissioner's response.

Legal Argument

I. The Petitioners Appeal is Moot.

By Order dated January 31, 2002, the Commissioner approved a new, modified Ambulatory Surgical Facilities Provider Class Plan submitted by BCBSM on December 17, 2001. This approval was given pursuant to the authority set forth in MCL 550.1508(1). (Respondent's Exhibit 6, pp. 2-3, 7.) This action rendered the Petitioners' appeal moot. Thus, the Independent Hearing Officer should deny the Petitioner's Motion.

In *Crawford County v Secretary of State*, 160 Mich App 88, 93 (1987) the Court of Appeals stated:

> An issue is moot when the occurrence of an event renders it impossible for the court to fashion a remedy.

In the instant matter the January 31, 2002 order of the Commissioner approved a new, modified Ambulatory Surgical Facilities Provider Class Plan. As a result, the Remedial Ambulatory Surgical Facilities Provider Class Plan which the Commissioner approved in his Order of March 29, 2001, is no longer effective. Thus, even if the Independent Hearing Officer were to grant the Petitioners' Motion, he could not fashion a remedy since any action which he might take would relate to the Remedial Ambulatory Surgical Facilities Provider Class Plan, which is no longer in effect. In other words, whatever action the Independent Hearing Officer

takes now would be a nullity since BCBSM is not operating under the Ambulatory Surgical Facilities Provider Class Plan approved by the Commissioner's Order of March 29, 2001 but, instead is operating under the new plan approved on January 31, 2002.

In *Attorney General v PSC*, 244 Mich App 401, 403 (2001), Detroit Edison wanted to suspend its power supply cost recovery (PSCR) clause for 1998. However, by the time that the Court of Appeals considered the request, calendar year 1998 had ended and the PSCR had been implemented. As a result, the Court could not grant Edison's request because:

> . . . the requests were rendered a nullity by the passage of time, where the window of implementation had passed and a rate for 1998 was set using the PSCR factor. Put simply, the PSC could not vacate what was already a nullity. *Id.*, p. 407.

Likewise in the instant matter, any action which the Independent Hearing Officer would take with regard to the Commissioner's March 29, 2001 Order would be a nullity since BCBSM is now operating under the Ambulatory Surgical Facilities Provider Class Plan approved by the Commissioner in his Order of January 31, 2002. Even if the Independent Hearing Officer were to grant the Petitioners' Motion and reverse the Commissioner's decision of March 29, 2001, it would not have any effect since the Commissioner's Order of January 31, 20002 is now effective. Thus, the Independent Hearing Officer should deny the Petitioners' Motion, because their appeal of the Commissioner's Order of March 29, 2001 is now moot.

II. The Petitioners Have Failed to Set Forth Any Authority Which Would Allow the Filing and Granting of Their Motion.

The Petitioners' Motion objects to the dismissal of their appeal, argues that the Independent Hearing Officer's Order does not comply with MCL 550.1515 and MCL 24.285 and requests a rehearing. However, the Petitioners have failed to cite any authority which allows the filing and granting of such motion. Moreover, 1980 PA 350, MCL 550.1101 *et seq* does not allow the filing and granting of such motion. Instead, MCL 550.1518 states that any appeal from a decision of an Independent Hearing Officer shall be by application for leave to the Court of

Appeals. *In re Provider Class Plan*, 203 Mich App 707, 716 (1994). Thus, the Independent Hearing Officer should not consider the Petitioners' Motion since the Petitioners have not provided any authority which allows the filing and granting of such motion.

III. The Independent Hearing Officer Properly Concluded That Res Judicata Bars the Instant Appeal.

The Petitioners correctly point out on page 5 of their Motion that:

> Res judicata bars a subsequent action between the same parties when the evidence or essential facts are identical. *Eaton Co Bd of Rd Comm's v Schultz*, 205 Mich App 371, 375; 521 NW2d 847 (1994). A second action is barred when:
> (1) the first action was decided on the merits,
> (2) the matter contested in the second action was or could have been resolved in the first, and
> (3) both actions involve the same parties or their privies. *Id.*, pp. 375-376.

Dart v Dart, 460 Mich 573, 586 (1999).

There is no question that the Petitioners raised the issue of whether BCBSM could have Evidence of Necessity standards, in *Vision Institute v BCBSM and Commissioner*, Ingham County Circuit Court Docket No. 98-089017-CZ as well as in their appeal of the Commissioner's Order of March 30, 2000, Docket No. 20001023. (See Commissioner's Brief dated June 22, 2001, pp. 11-15.) This is the same issue that the Petitioners have raised herein. Moreover, these actions involved the same parties and these actions were decided on the merits. Thus, under the holding of *Dart, supra*, the Independent Hearing Officer was correct in concluding that res judicata barred the Petitioners from raising the same issue regarding Evidence of Necessity standards in this case.

The Petitioners argue on page 3 of their Motion that 1980 PA 350 does not provide for the use of previous provider class plan decisions. However, they cite no authority to support that proposition. Moreover, in *Kosiel v Arrow Liquors Corp.*, 446 Mich 374, 380 (1994) and *Roman Cleanser Company v Murphy*, 386 Mich 698, 703-704 (1972), the Supreme Court held that the doctrine of res judicata applied to a final order issued in an administrative matter. Clearly the

decision issued by Independent Hearing Officer Nichols in Docket No. 20001023 was a final order which found that BCBSM could have Evidence of Need standards and that the Commissioner was correct in allowing BCBSM to have such standards. (See Respondent's Exhibit 2.)

The Petitioners also argue, on page 5 of their Motion, that res judicata does not apply because there was no published court decisions resolving the issue of the Evidence of Necessity standard. However, again, the Petitioners have failed to cite any authority which requires that a decision be published in order for res judicata to apply. Since most administrative decisions are never published, for the Supreme Court to conclude that res judicata applies to a final order issued in an administrative matter, the Court must have concluded that res judicata applies to unpublished decisions.

On page 6 of its Motion the Petitioners appear to be arguing that the issues which they raised in their appeal could not have been raised previously in the appeal before Independent Hearing Officer Nichols or in the Circuit Court action filed in 1998. However, this is not supported by the facts. In the instant matter, the Petitioners are arguing that BCBSM should not be allowed to have an Evidence of Necessity standard to evaluate whether an ambulatory surgery facility should be allowed to participate with it. The Petitioners claim that Evidence of Necessity standard is ultra vires and infringes on the states licensure authority. (See Petitioners Petition for Review, ¶¶ 33-38, 41-51, 61-67 and 74.)

Independent Hearing Officer Nichols specifically found:

> 15. The Commissioner properly concluded that BCBSM could have reasonable evidence of need standards applicable to all licensed ambulatory surgical facilities who wish to participate with it.

(See Respondent's Exhibit 2, p. 3.) Ingham County Circuit Court Judge William E. Collette held:

> Further, this Court finds no error on the part of BCBSM in using evidence of necessity/need requirement . . . .

(Respondent's Exhibit 1, p. 9.) Thus, the issues raised in the instant matter have previously been raised and decided. In other words, the Petitioners have consistently argued that BCBSM could not have Evidence of Needs standards in both the Circuit Court litigation, the appeal decided by Independent Hearing Officer Nichols and the instant matter. Thus, res judicata applies.

While the Remedial Ambulatory Surgical Facilities Provider Class Plan, which the Commissioner approved in his Order of March 29, 2001, did not exist at the time of the decision of Independent Hearing Officer Nichols, the concept that the Petitioners are attacking in the Remedial Ambulatory Surgical Facilities Provider Class Plan is the same. That is, the Petitioners continue to argue that BCBSM cannot have Evidence of Needs standards. This issue was clearly decided by Independent Hearing Officer Nichols. Thus, res judicata applies.

On page 8 of their Motion, the Petitioners argue that they could not litigate the issue of the Ambulatory Surgery Facilities Provider Class Plan because Independent Hearing Officer Nichols dismissed their appeal. However, pursuant to MCL 550.1518, the Petitioners could have filed an Application for Leave to Appeal in the Michigan Court of Appeals of Independent Hearing Officer Nichol's decision but failed to do so. Thus, the Petitioners cannot now argue that they could not litigate the matter when they simply chose not to do so.

On page 10 of their Motion, Petitioners argue that the Commissioner's approval of BCBSM's remedial plan, in his Order of March 29, 2001, made any decisions based on the previous plan moot. However, as previously noted, the Court of Appeals defined mootness as follows:

> An issue is moot when the occurrence of an event renders it impossible for the court to fashion a remedy.

Crawford, supra, p. 93. The Commissioner's decision of March 30, 2000, wherein he approved BCBSM's use of evidence of needs standards, clearly established the Commissioner's position as to whether BCBSM could have Evidence of Needs standards. That position was challenged by the Petitioners in its appeal before Independent Hearing Officer Nichols who affirmed the Commissioner's decision. The Petitioners did not file any further appeal of Independent Hearing Officer Nichol's decision. Thus, it became a final decision which was res judicata to the issue being raised by the Petitioners in the instant matter. Thus, the Commissioner's decision of March 29, 2001, may have made his decision of March 30, 2000 moot but, it did not stop the application of the doctrine of res judicata.

In summary, since the issues raised by the Petitioners in the instant matter were previously decided by the Independent Hearing Officer Nichols and the circuit court, the doctrine of res judicata applies and the Petitioners are barred from raising the same issues again. Thus, the Independent Hearing Officer was correct in granting the Commissioner's Motion for Summary Disposition and dismissing the Petitioner's appeal.

IV. The Factual Allegations Made by the Petitioners Cannot be Relied Upon by the Independent Hearing Officer in Reaching his Conclusion.

On pages 12 through 15 of their Motion, the Petitioners argue that they have discovered information which supports a claim that BCBSM is knowingly and deliberately applying its discriminatory practices that exclude physician owned non-hospital affiliated ambulatory surgery facilities from participating with BCBSM. However, this argument is misplaced and should not be relied upon by the Independent Hearing Officer as a basis for granting the Petitioners' Motion for Reconsideration in two respects: 1) These alleged facts do not relate to whether the Commissioner properly approved BCBSM's Remedial Ambulatory Surgical Provider Class Plan under the provisions of MCL 550.1513(1). 2) The Petitioners have failed to supply any documentary evidence to support these allegations. Without documentary evidence to support

the allegations there is no basis to grant the Petitioner's Motion and overturn the Independent Hearing Officer's previous decision. *Morgan v United* States, 298 U.S. 468, 480 (1934). Thus, the Independent Hearing Officer should disregard the arguments made by the Petitioners on pages 12 through 15 of their Motion.

V. The Case of *Blakewoods Surgery Center, LLC, et al v Michigan Insurance Commissioner*, Supreme Court No. 118935 has no Applicability to the Instant Matter.

On page 11 of their Motion, the Petitioners quote from the Supreme Court's Order of October 23, 2001, in the matter entitled *Blakewoods Surgery Center, LLC, et al v Michigan Insurance Commissioner*, Supreme Court No. 118935. In that case the Plaintiffs filed suit against the Commissioner alleging the same kinds of issues that the Petitioners raised in their Circuit Court action entitled *Vision Institute, et al v BCBSM and Commissioner*, Ingham Count Circuit Court Docket No. 98-089017-CZ. The Circuit Court similarly dismissed the *Blakewoo* Circuit Court action and the Court of Appeals affirmed. *Blakewoods* filed an application for leave to appeal which is presently pending. (See Petitioners' Exhibit 3, attached to their Motio The fact that the Supreme Court has asked the question, which the Petitioners have quoted in their Motion, has no impact on whether the Independent Hearing Officer should grant the Petitioners' Motion. What, if anything, the Supreme Court does in the *Blakewoods, supra* mat will have no impact on whether the Independent Hearing Officer properly dismissed the Petitioners appeal based on the doctrine of res judicata. Thus, this argument of the Petitioners irrelevant and should not be used by the Independent Hearing Officer as a basis for granting th Petitioner's Motion.

VI. The Independent Hearing Officer's Order of January 24, 2002, Does not Violate MCL 24.285, nor MCL 550.1515(3)(b)(i).

The Petitioners argue on pages 3 and 4 of their Motion that the Independent Hearing Officer's decision of January 24, 2002, violates MCL 24.285 and MCL 550.1515(3)(b)(i). This argument is not supported by the law or the facts.

The Petitioner argues on page 3 of their Motion that the Independent Hearing Officer failed to comply with MCL 550.1515(3)(b)(i) and determine if the Remedial Ambulatory Surgical Facilities Provider Class Plan was properly prepared. However, the Independent Hearing Officer granted the Commissioner's Motion for summary disposition on the basis of the doctrine of res judicata. This issue was dispositive. As a result, the Independent Hearing Officer dismissed the Petitioners' appeal. (Petitioners' Exhibit 1, attached to their Motion.) Thus, there was no need for the Independent Hearing Officer to determine if the provider class plan prepared by BCBSM was properly prepared because the challenge to the plan was dismissed. In other words, since the appeal could not be heard, there was no basis upon which to determine if the Remedial Plan was properly prepared.

On page 4 of their brief, the Petitioners argue that the Independent Hearing Officer's decision of January 24, 2002, fails to comply with MCL 24.285 because it fails to cite any statutory authority or case law that it relies upon. However, MCL 24.285 does not require that a decision cite statutory or case law. Instead, MCL 24.285 simply requires that the Independent Hearing Officer make conclusions of law. The Independent Hearing Officer's decision did conclude that the appeal would be denied and the Commissioner's Motion granted under the doctrine of res judicata because the issues raised by the Petition for Appeal were previously decided by the Circuit Court and Independent Hearing Officer Nichols. That is all that need be said by the Independent Hearing Officer.

In *Dyer v Department of State Police*, 119 Mich App 121, 126 (1982), one of the issues was whether the Hearing Officer made findings of fact and conclusions of law on two of the arguments raised by the Plaintiffs. The Court found that there was no need to reverse the Hearing Officer's decision because these two issues could be disposed of as a matter of law. Thus, no findings of fact need be made. In the instant matter, the central issue raised in the Commissioner's Motion was whether the doctrine of res judicata barred the Petitioners from raising the same issues that had been previously disposed of in other litigation. There were no issues of fact in dispute and thus no findings of fact need be made. The question was clearly one of law as to whether the issues that the Petitioners raised in their appeal had been previously raised and decided so that the doctrine of res judicata barred the Petitioners from raising them again. Thus, the Independent Hearing Officer's decision did not violate MCL 24.285.

The Petitioners also argue that the Independent Hearing Officer's statement that "the Petitioners argued the same issues in Circuit Court in 1968" is untrue. This statement appears to be a typographical error in that "1968" should be "1998" since that is the time when the *Vision Institute v BCBSM and Commissioner*, Ingham County Circuit Court Docket No. 98-089017-CZ was initiated. In the case entitled *In re: Joe Brown and Sons*, 273 Mich 652, 656 (1935) the Michigan Supreme Court stated:

> The law is well settled that *quasi* judicial bodies, like courts, may, of their own motion or by request, correct or amend any order still under their control without notice or hearing to the interested parties provided such parties cannot suffer by reason of the correction or amendment, or if the matters corrected or amended were embraced in testimony taken at a previous hearing.

Here clearly, the Independent Hearing Officer can issue a corrected order to clearly indicate the proper date that he intended in paragraph 1 of his Order. The Independent Hearing Officer does not have to grant the Petitioner's Motion in order to do so because it clearly is a clerical error.

Petitioners also take issue with the Independent Hearing Officer's conclusion that the same issues were involved in a subsequent case. This issue has been exhaustively addressed herein and the decisions of the circuit court and the Independent Hearing Officer Nichols are clearly applicable to cause res judicata to apply.

Petitioners further take issue with the Independent Hearing Officer's paragraph 3 where he states that the issue was decided in previous cases without naming those cases. However, there is no dispute that cases were *Vision Institute, et al v BCBSM and Commissioner*, Ingham County Circuit Court Docket No. 98-089017-CZ and *Blakewoods Surgery Center, et al and Vision Institute, et al v Michigan Commissioner of Financial and Insurance Services*, Docket No. 20001023, Agency No. 00-234-BC. Since both of these cases had been provided to the Independent Hearing Officer with the Commissioner's brief dated June 22, 2001, there can be no misunderstanding of what cases the Independent Hearing Officer was referring to. The Independent Hearing Officer can correct his order to reflect that fact. *In re: Brown,* supra, p. 656. Thus, this argument is not a basis for granting Petitioners' Motion.

Petitioners also argue on page 4 of their Motion that the Independent Hearing Officer's decision is in error where it states, "The court finds that the issues agreed are identical." Again, this appears to be a typographical, clerical error. It appears that the word "agreed" should have been "argued". Under the holding of *In re Joe Brown, supra*, p. 656, the Independent Hearing Officer can correct this alleged error without granting the Petitioner's Motion.

Finally, the Michigan Supreme Court set forth a standard which should govern administrative hearings and orders in *Viculin v Department of Civil Service*, 386 Mich 375, 405-406 (1971) as follows:

> Courts are indulgent toward administrative action to the extent of affirming an order where the agency's path can be 'discerned' even if the opinion 'leaves much to be desired'."

Here, the Independent Hearing Officer's path can be discerned. He granted the Commissioner's Motion for Summary Disposition and dismissed the Petitioner's appeal because the appeal raise the same arguments that had been previously raised in other cases and therefore, under the doctrine of res judicata, the Petitioner could not raise the same issues again. Thus, the Independent Hearing Officer should not grant the Petitioners' Motion.

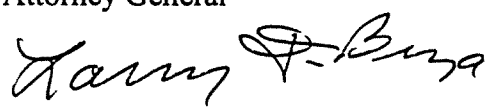
In summary, the Independent Hearing Officer's decision can be reissued to correct the clerical and typographical errors in it without granting the Petitioners' Motion for Rehearing. Moreover, the Independent Hearing Officer's decision does contain sufficient findings and conclusions of law since the issue here was a matter of law.

Relief Requested

Wherefore the Respondent Commissioner of the Office of Financial and Insurance Service requests that the Independent Hearing Officer reissue his Order to correct the typographical and clerical errors in it. The Commissioner further requests that the Independent Hearing Officer deny the Petitioners' Motion for the reasons stated herein.

Respectfully submitted,

JENNIFER M. GRANHOLM
Attorney General



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Dated: February 19, 2002

STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
BUREAU OF HEARINGS

In the matter of

Vision Institute of Michigan
Surgery Center, P.C.,
Laurence Loewenthal, M.D., &
Jay Novetsky, M.D.,
Petitioners,
v
Frank M. Fitzgerald, Commissioner of
the Office of Financial & Insurance
Services, in his official capacity,
Respondent
_____/

Docket No. 2001-680

Agency No. 01-286-BC

Agency: Office of Financial & Insurance Services

Case Type: Appeal Subscriber/Provider

Issued and entered
this 24th day of January, 2002
by John P. O'Brien
Independent Hearing Officer

ORDER FOR DISMISSAL

The Court finds:

1. The Petitioner has argued the same issues in Circuit Court in 1968. The Court dismissed that case. The order was affirmed by the Court of Appeals.

2. The same issues were involved in a subsequent case.

3. The Petition for appeal and the motion filed by Vision are dismissed because the issue was decided in the previous cases. The Court finds that the issues agreed are identical.

The appeal is denied and under the doctrine of Res Judicata the motion of respondent for summary judgement is hereby granted.

John P. O'Brien
Independent Hearing Officer

STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner

In the matter of the Ambulatory Surgical Facilities
Provider Class Plan Modification Determination
Report Pursuant to P.A. 350 of 1980
_____/

No. 02-003-BC

Issued and entered
This 31st day of January, 2002
By Frank M. Fitzgerald

ORDER APPROVING BLUE CROSS BLUE SHIELD OF MICHIGAN MODIFICATION TO THE AMBULATORY SURGICAL FACILITIES PROVIDER CLASS PLAN

BACKGROUND

On July 6, 1999, the Commissioner of Insurance issued Order No. 99-117-BC, giving notice to Blue Cross Blue Shield of Michigan (BCBSM), and to each person having requested a copy of such notice, of his intent to make a determination with respect to the ambulatory surgical facilities (ASF) provider class plan for calendar years 1996 and 1997. After analyzing all available information, including the input obtained in accordance with MCL 550.1505(2), the Commissioner's determination with respect to his review of the ASF provider class plan in effect during calendar years 1996 and 1997 was set forth in Order No. 00-007-BC dated March 30, 2000.

In his order of March 30, 2000, the Commissioner found that BCBSM's ASF provider class plan did not substantially achieve the access and quality of care goals as provided in MCL 550.1504. Inasmuch as BCBSM failed to demonstrate that its failure to meet either of these goals was reasonable, the determination report was issued pursuant to MCL 550.1510(1)(c). This finding required BCBSM to transmit, in accordance with MCL 550.511(1), a remedial ASF provider class plan that substantially achieves the goals, achieves the objectives and substantially overcomes the deficiencies enumerated in the determination report within a six month period. BCBSM requested an extension of 90 days to file a remedial plan, as provided by MCL 550.1512, to allow time to conduct two large advisory meetings and to circulate draft revisions to participants. The

Commissioner considered BCBSM's request for the 90-day extension to file the remedial plan and granted BCBSM an extension through December 29, 2000.

The Office of Financial and Insurance Services (OFIS) received BCBSM's remedial plan on December 29, 2000. On January 3, 2001, OFIS sent all interested parties of record a copy of the remedial ASF provider class plan, requesting that written advice and consultation with respect to the remedial plan be filed with OFIS by January 31, 2001.

After an extensive review of BCBSM's remedial ASF provider class plan conducted pursuant to MCL 550.1513(1), the Commissioner found that the remedial ASF provider class plan filed by BCBSM on December 29, 2000 substantially achieved the goals, achieved the objectives and substantially overcame the deficiencies enumerated in the findings made by the Commissioner in the March 30, 2000 determination report. As such, BCBSM's remedial ASF provider class plan was retained and placed into effect in accordance with MCL 550.1506.

On December 17, 2001, BCBSM filed modifications to the ASF provider class plan with the Commissioner for approval. BCBSM is proposing two substantive modifications. The first modification to the plan would provide for an extension of the Evidence of Need (EON) transition period. In essence, this modification would grant a six-month extension of time to meet BCBSM's EON standard to all currently participating ASFs that do not meet BCBSM's EON standard but meet all of its other qualification standards. During the extended EON transition period, nonparticipating ASFs would be allowed to qualify for participation based on their most recent six months volumes. The second modification to the plan would change the recertification period from once every year to once every other year. Under the recertification process, all providers must demonstrate that they meet BCBSM's participation requirements in order to continue participating with BCBSM.

DISCUSSION

MCL 550.1508(1)(a) and (b) provides that BCBSM may modify a provider class plan under the following circumstances: "(a) If the plan was prepared by the health care corporation and is not a plan prepared pursuant to section 511(1) or 515(4). However, the modification shall not take effect until after the modification has been filed with the commissioner; (b) in all other cases, if the modification has been filed with and is agreed to by the commissioner."

Since the plan that BCBSM is proposing to modify was not prepared pursuant to Section 511(1) or 515(4), then the modification that BCBSM is proposing falls under Section 508(1)(b) and must therefore be agreed to by the Commissioner before it can become effective.

Pursuant to MCL 550.1508(2), "In developing plan modifications, a health care corporation shall obtain advice and consultation from providers in the relevant provider class and from subscribers pursuant to section 505. Before agreeing to plan modifications under subsection (1)(b), the commissioner shall obtain advice and consultation pursuant to section 505(2)." Advice and consultation was sought by OFIS through a posting of the proposed modifications on the OFIS website. Written notice seeking advice and consultation was also sought from all persons who had previously expressed an interest in BCBSM's ASF provider class plans. Written input was accepted from January 7 through January 23, 2002.

Although no subscribers responded, input was received from providers by BCBSM pursuant to an October 29, 2001 provider input meeting hosted by BCBSM. This input was summarized by BCBSM, and the summary was provided to OFIS. Copies of written comments received by BCBSM were also provided to OFIS. The following is a summary of all the comments received by OFIS:

Summary of Comments from Providers Attending BCBSM Meeting

Thirty individuals representing 11 hospitals and 11 physician-owned facilities attended BCBSM's provider input meeting held on October 29, 2001. BCBSM summarized the outcome of the meeting stating that the majority of the providers attending the meeting supported the amendments, as they would help increase network stability. However, they also said that the amendments do not go far enough. They felt the amendments should better address the definition of rural versus urban; allow providers with multiple facilities to combine volumes; and extend the transition period for 2 years (rather than six months).

Some providers stated that they were generally opposed to any sort of evidence of need volume or operating room requirements. One provider indicated that the only fair long-term solution is to lower the volume and operating room requirements "across the board". Two providers (one hospital and one not-hospital) stated that they did not support the amendments because they felt that they would result in further grandfathering of existing facilities that do not meet current standards.

Written Comments Received by BCBSM

Three letters from non-hospital facilities are nearly identical. These letters state that BCBSM's proposed change to the EON perpetuates BCBSM discrimination against independently owned ASFs in violation of 550.1502. They believe that the plan approved by OFIS should be enforced exactly as written, and they do not support modifications to the plan unless the EON is completely eliminated for all ASFs. In addition, the re-certification program is completely inconsistent with BCBSM's prior stated position that promoted the idea that ASF size and volume was somehow a "quality and safety" issue. One other non-hospital ASF wrote specifically about the re-certification program. That ASF still contends that BCBSM's re-certification program has no scientific, measurable link. If the re-certification program based in volume is such an important measure of safety and quality, why is BCBSM proposing to change it?

Two other letters were from other non-hospital ASFs. The sentiments include the same above discussion and go on to speak about how the whole process is a political one rather than one based on logic or scientific data. They believe that it would be more reasonable to adjust the EON to 800 cases (the average number of ASF cases per surgical room in 1999) and eliminate the minimum room requirement. Doing this would eliminate the need for any rural adjustment. They believe that this change would result in at least 34 ASFs qualifying for participation, bringing the par rate to between 50-70%.

The last letter was from a hospital-owned ASF. This ASF supports the amendments but does not believe that the amendments go far enough. There is no rational connection to cost, quality or access for a hospital-based ASF to have to close surgery rooms when it performs 3,600 procedures and has three or more operating rooms. Second, decertifying hospital based ASFs will disrupt patient care. Also those to be terminated are multi-specialty when the new facilities accepted are mostly single specialty. Third, while a numerical measure is a good proxy for quality for some services like transplants or open-heart surgery, it is not a credible indicator for low risk ambulatory care services performed in an ASF. Accreditation and affiliation with licensed and accredited hospitals are far better indicators. Requirements such as integrated medical staff, common medical record, common grievance, administration, clinical oversight and financial integration are used to evidence a level of integration to assure quality. These are the things that Medicare and other insurers require. Lastly, payment for services are set by billing code no matter whether done in a hospital based or freestanding ASF. Currently there is a shortage of multi-specialty ambulatory services. The growth of hospital affiliated multi-specialty ambulatory surgery capacity reduces overall costs. Loss of such capacity increases cost. Most

importantly, having to close operating rooms in operating ASFs results "in a significant waste of fully paid capital resources".

Comments Received by OFIS

The physician owner of one ASF claims that the modifications are an attempt to circumvent the appeal process. The access goal wasn't met in the original plan, the remedial plan still won't meet the access goal if the modifications are approved.

One person wrote on behalf of three non-hospital ASFs that were granted approval to participate after acceptance of the remedial plan. These three ASFs believe that the modifications are fair and resolve the concerns regarding physician pattern changes.

The physician owner of yet another ASF indicates that the merits of the CON (certificate of need) legislation are currently being reviewed in the legislature. He claims that the Federal Trade Commission has gone on record in opposition to the standards on which the EON is based. As far as access, participation rates did not increase because of the restrictive EON standards. The remedial plan is fundamentally flawed. As far as quality, there is no scientific evidence that the number of rooms or procedures is linked to the quality of patient outcomes. He claims that there are currently six hospital ASFs that don't meet the minimum number of rooms and 4 hospital ASFs that don't meet the volumes, yet they are considered facilities with high enough quality for BCBSM to participate with them right now. As far as the transition period and re-certification periods – either the EON requirements and re-certification period are quality standards or they are not. There are a number of non-hospital based ASFs that reclassified themselves from multi-specialty to single specialty; one ASF delicensed an operating room that cost $1 million to build and license. Another ASF is investing $3 million in an expansion plan. Overall, this provider estimates that non-hospital ASFs have made $10 million in financial sacrifices while hospital ASFs have sacrificed nothing. In his opinion, no hospital based ASFs have made attempts to change anything. Lastly, this provider speaks about inequity. If hospitals had to meet the same BCBSM EON criteria, 93% would not meet the criteria. He noted that the Michigan Department of Community Health classifies all operating rooms (hospital and ASF) the same.

A representative of two other physician-owned ASF reiterated these same comments. The first person also added that the only modifications that should be allowed are to eliminate or modify the EON requirement. It should be noted that this ASF meets the BCBSM participation requirements but chooses not to participate with BCBSM. The second person added his claim that BCBSM's

modification is just a "band-aid" solution of continuing to participate with non-qualifying hospital facilities to increase the participation rates. It states it would be better to use the average 1999 volume data of 800 cases per room in setting the EON. That would still leave par rates at less than 70%.

A hospital-based ASF supports the transition period, but continues to be concerned about the overall ASF plan. This provider fails to see how reducing its operating rooms from to 6 to 4 at one ASF and from 5 to 3 at another site will reduce cost, improve quality or improve access. This provider wants another amendment to "preserve patient access to existing ambulatory surgery facilities so long as the facility has at least 3 operating rooms and the 3,600 procedure threshold is met" (in order to participate).

Another physician-owned ASF now participating with BCBSM notes that OFIS continues to let BCBSM do whatever it wants; this person believes there is no evidence that the EON promotes quality of care. Public input is "like shouting down an empty well and the only sounds we hear in return are our voices echoing back at us." This person believes the EON process is illegal and that modification of an illegal provision is still illegal.

Lastly, a physician from another hospital not affiliated with any ASF states he believes that the remedial plan should remain intact and the modifications rejected because it has only been 9 months since the modified plan was put into effect. He asks OFIS to remember the major objective of PA 350 when looking at the modifications was to ensure the delivery of high-quality health care services while controlling costs. A well-defined EON transition period (which the remedial plan already had) was to have leveled the playing field. Extending the transition period will likely further increase the number of participating facilities and thus increase costs. In this time of budgetary shortfalls, increases in cost should not be allowed to continue. OFIS should deny BCBSM's modifications. Further, the re-certification period change should not be allowed either. If surgical volume is directly related to the health care quality as OFIS claims, and if quality is a major PA 350 goal, then annual re-certification is a necessity, not an option.

ANALYSIS

MCL 550.1504(1) requires a health care corporation to "contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to and reasonable cost and quality of health care services". One of the goals that must be met under the reimbursement arrangement is to ensure "an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber".

In the Commissioner's order determining the goal achievement of BCBSM's remedial ASF provider class plan dated March 29, 2001, it was noted that in the first year of BCBSM's remedial plan, the estimated participation rate was to have increased from 36% to 45%. According to recent statistics provided by BCBSM, the current participation rate is 53%. If the Commissioner does not agree to BCBSM's proposed modifications to the ASF class plan, access will deteriorate for BCBSM members by 10 facilities, and the participation rate will be reduced to only 37% -- only 1% higher than the participation rate before the remedial plan was placed into effect. Even if the Commissioner agrees to BCBSM's proposed modifications, the participation rate will still be reduced from the current 53% to 47% (see attached document to this order).

Further, the Commissioner is concerned over the quality and continuity of care provided to BCBSM's members. If BCBSM were forced to abruptly departicipate with these 10 ASFs, any BCBSM member who might have had a surgical procedure already scheduled would have to cancel that procedure, locate another facility that could perform the surgery, and be forced to wait an additional period before the medically-necessary service could be performed. Regardless of the differences in opinion among the provider community regarding BCBSM participation requirements for ASFs, this seems patently unfair to BCBSM's members needing medical services.

[redacted]

3. BCBSM and each person who has requested a copy of the Commissioner's determination in this matter shall be provided with a copy by certified or registered mail.

4. An appeal of this order may be filed pursuant to MCL 600.631, MCR 7.104 and MCR 7.101 within 21 days after the date of this order.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary and appropriate.

Frank M. Fitzgerald
Commissioner

Provider Class Region	Total Providers*	Currently Participating Providers	Current Par Rate	Par Providers After Approval	Projected Par Rate	Par Providers After Transition Period	Projected Par Rate	Par Providers Without Approval	Projected Par Rate
1	35	17	49%	14	40%	13	37%	9	26%
2	1	0	0%	0	0%	0	0%	0	0%
3	4	2	50%	2	50%	2	50%	2	50%
4	3	1	33%	1	33%	1	33%	1	33%
5	7	6	86%	5	71%	5	71%	5	71%
6	6	4	67%	4	67%	4	67%	4	67%
7	2	2	100%	2	100%	2	100%	1	50%
8	1	1	100%	1	100%	1	100%	1	100%
9	3	0	0%	0	0%	0	0%	0	0%
	62	33	53%	29	47%	28	45%	23	37%
Hosp/Non Hosp		23/10		19/10		18/10		13/10	

* Excludes providers of non-covered services (e.g., Planned Parenthood, plastic surgery)

Includes Health Care Midwest (region 5) - BCBSM doesn't intend to terminate on 2/1/02 as it has received CON approval to build 2 more ORs. ORs are not built yet but BCBSM anticipates the ORs will be built by end of transition period

3 hospitals in region one and 1 hospital in region 5 will not meet OR requirements and will be terminated 2/01/02

The only regions affected by modification approval are regions 1 and 7

STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
BUREAU OF HEARINGS
Michael Zimmer, Director

In the matter of:

Vision Institute of Michigan
Surgery Center, PC,
Laurence Loewenthal, MD, and
Jay Novetsky, MD,

Petitioners,

v

Frank M. Fitzgerald, Commissioner of the
Office of Financial & Insurance Services,
in his official capacity,

Respondent.
_____/

Docket No. 2001-680

Agency No. 01-286-BC

Agency: Office of Financial & Insurance Services

Case Type: Appeal Subscriber/Provider

ORAL ARGUMENT REQUESTED

RESPONDENT'S BRIEF IN OPPOSITION TO "PETITIONERS MOTION OBJECTION TO ORDER FOR DISMISSAL BASED, IN PART, ON NON-COMPLIANCE WITH MCL 550.1515 AND MCL 24.285, AND REQUEST FOR REHEARING/RECONSIDERATION AND REQUEST FOR ADDITIONAL FINDINGS DUE TO MISREPRESENTATIONS RELIED UPON BY THE RESPONDENT AND THE TRIBUNAL"

Introduction

The Petitioners' Motion should be rejected for at least six reasons:

1. The Petitioners' Appeal is moot.

2. The Petitioners have failed to set forth any statutory or case law which allows the fil of such motion subsequent to the issuance of a decision by an Independent Hearing Officer.

3. The Petitioners have failed to set forth any palpable error made by the Independent Hearing Officer which would justify the granting of a motion for rehearing.

4. The Petitioners have failed to support their factual allegations with any admissible evidence.

Circuit Court and before Independent Hearing Officer Nichols. Independent Hearing Officer O'Brien reached this conclusion based upon the doctrine of res judicata.

On December 12, 2001, BCBSM submitted modifications to its Ambulatory Surgical Facilities Provider Class Plan. In an Order dated January 31, 2002, the Commissioner approved those modifications. (Respondent's Exhibit 6.)

On February 7, 2002, the Petitioners filed the instant Motion. Following is the Commissioner's response.

Legal Argument

I. The Petitioners Appeal is Moot.

By Order dated January 31, 2002, the Commissioner approved a new, modified Ambulatory Surgical Facilities Provider Class Plan submitted by BCBSM on December 17, 2001. This approval was given pursuant to the authority set forth in MCL 550.1508(1). (Respondent's Exhibit 6, pp. 2-3, 7.) This action rendered the Petitioners' appeal moot. Thus, the Independent Hearing Officer should deny the Petitioner's Motion.

In *Crawford County v Secretary of State*, 160 Mich App 88, 93 (1987) the Court of Appeals stated:

> An issue is moot when the occurrence of an event renders it impossible for the court to fashion a remedy.

In the instant matter the January 31, 2002 order of the Commissioner approved a new, modified Ambulatory Surgical Facilities Provider Class Plan. As a result, the Remedial Ambulatory Surgical Facilities Provider Class Plan which the Commissioner approved in his Order of March 29, 2001, is no longer effective. Thus, even if the Independent Hearing Officer were to grant the Petitioners' Motion, he could not fashion a remedy since any action which he might take would relate to the Remedial Ambulatory Surgical Facilities Provider Class Plan, which is no longer in effect. In other words, whatever action the Independent Hearing Officer

is now would be a nullity since BCBSM is not operating under the Ambulatory Surgical Facilities Provider Class Plan approved by the Commissioner's Order of March 29, 2001 but, instead is operating under the new plan approved on January 31, 2002.

In *Attorney General v PSC*, 244 Mich App 401, 403 (2001), Detroit Edison wanted to suspend its power supply cost recovery (PSCR) clause for 1998. However, by the time that the Court of Appeals considered the request, calendar year 1998 had ended and the PSCR had been implemented. As a result, the Court could not grant Edison's request because:

> . . . the requests were rendered a nullity by the passage of time, where the window of implementation had passed and a rate for 1998 was set using the PSCR factor. Put simply, the PSC could not vacate what was already a nullity. *Id.*, p. 407.

Likewise in the instant matter, any action which the Independent Hearing Officer would take with regard to the Commissioner's March 29, 2001 Order would be a nullity since BCBSM is now operating under the Ambulatory Surgical Facilities Provider Class Plan approved by the Commissioner in his Order of January 31, 2002. Even if the Independent Hearing Officer were to grant the Petitioners' Motion and reverse the Commissioner's decision of March 29, 2001, it would not have any effect since the Commissioner's Order of January 31, 20002 is now effective. Thus, the Independent Hearing Officer should deny the Petitioners' Motion, because their appeal of the Commissioner's Order of March 29, 2001 is now moot.

II. The Petitioners Have Failed to Set Forth Any Authority Which Would Allow the Filing and Granting of Their Motion.

The Petitioners' Motion objects to the dismissal of their appeal, argues that the Independent Hearing Officer's Order does not comply with MCL 550.1515 and MCL 24.285 and requests a rehearing. However, the Petitioners have failed to cite any authority which allows the filing and granting of such motion. Moreover, 1980 PA 350, MCL 550.1101 *et seq* does not allow the filing and granting of such motion. Instead, MCL 550.1518 states that any appeal from a decision of an Independent Hearing Officer shall be by application for leave to the Court of

Here, the Independent Hearing Officer's path can be discerned. He granted the Commissioner's Motion for Summary Disposition and dismissed the Petitioner's appeal because the appeal raised the same arguments that had been previously raised in other cases and therefore, under the doctrine of res judicata, the Petitioner could not raise the same issues again. Thus, the Independent Hearing Officer should not grant the Petitioners' Motion.

In summary, the Independent Hearing Officer's decision can be reissued to correct the clerical and typographical errors in it without granting the Petitioners' Motion for Rehearing. Moreover, the Independent Hearing Officer's decision does contain sufficient findings and conclusions of law since the issue here was a matter of law.

Relief Requested

Wherefore the Respondent Commissioner of the Office of Financial and Insurance Service requests that the Independent Hearing Officer reissue his Order to correct the typographical and clerical errors in it. The Commissioner further requests that the Independent Hearing Officer deny the Petitioners' Motion for the reasons stated herein.

Respectfully submitted,

JENNIFER M. GRANHOLM
Attorney General

Larry F. Brya (P26088)
Assistant Attorney General
Insurance & Banking Division
P.O. Box 30212
Lansing, MI 48909
(517) 373-1160
Fax: (517) 335-6755

Dated: February 19, 2002

STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
BUREAU OF HEARINGS

In the matter of	**Docket No. 2001-680**
Vision Institute of Michigan Surgery Center, P.C., Laurence Loewenthal, M.D., & Jay Novetsky, M.D., Petitioners,	**Agency No. 01-286-BC**
v	**Agency: Office of Financial & Insurance Services**
Frank M. Fitzgerald, Commissioner of the Office of Financial & Insurance Services, in his official capacity, Respondent	**Case Type: Appeal Subscriber/Provider**

Issued and entered
this 24th day of January, 2002
by John P. O'Brien
Independent Hearing Officer

ORDER FOR DISMISSAL

The Court finds:

1. The Petitioner has argued the same issues in Circuit Court in 1968. The Court dismissed that case. The order was affirmed by the Court of Appeals.

2. The same issues were involved in a subsequent case.

3. The Petition for appeal and the motion filed by Vision are dismissed because the issue was decided in the previous cases. The Court finds that the issues agreed are identical.

The appeal is denied and under the doctrine of Res Judicata the motion of respondent for summary judgement is hereby granted.

John P. O'Brien
Independent Hearing Officer

STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL

WILLIAM J. RICHARDS
Deputy Attorney General

P.O. BOX
LANSING, MICHIGAN

JENNIFER MULHERN GRANHOLM
ATTORNEY GENERAL

August 18, 2000

Linda Sue Fausey
328 N. Walnut
Lansing MI 48933

Dear Ms. Fausey:

Re: Rehabilitation Therapy Provider Class Plan

This is in response to your letter of July 26, 2000 regarding your concerns about the Rehabilitation Therapy Provider Class Plan filed by Blue Cross and Blu Shield of Michigan on February 15, 2000.

MCL 550.1506(1) requires BCBSM to transmit a copy of each Provider Class Plan to the Commissioner. Pursuant to Subsection 2, the Commissioner is requi to examine the Plan and determine "... only if the Plan contains a reimburseme arrangement and objectives for each goal provided in Section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract." It is my understanding that the Commissioner compl with the provisions of MCL 550.1506(2) and concluded that the Plan did meet tha statutory requirement. Pursuant to MCL 550.1509, the Commissioner may not review the Plan further until at least 2 years after it's filing date.

You advise that the Rehabilitation Therapy Provider Class Plan filed on February 15, 2000 contains a requirement that Independent Physical Therapists obtain a Medicare supplier number in order to participate with BCBSM. As you a aware, MCL 550.1105(4), MCL 550.1107(1), MCL 550.1502(3), and MCL 550.1504(1)(b clearly allow BCBSM to establish reasonable standards for those who wish to participate with BCBSM. Whether the requirement for Medicare supplier numb is a reasonable standard is an issue which may be addressed in the next review of Rehabilitation Therapy Provider Class Plan.

You state that neither the Michigan Physical Therapy Association nor P.T. Today, Inc. agreed to the requirement that Independent Physical Therapists have a Medicare supplier number in order to participate with BCBSM. However,

am not aware of any statutory requirement which requires BCBSM to obtain the agreement of the Michigan Physical Therapy Association and P.T. Today, Inc. before it files a modification to the Rehabilitation Therapy Provider Class Plan.

You also cite various provisions from the Commissioner's Order in *In the matter of the Rehabilitation Therapy Provider Class Plan Determination Report, Pursuant to P.A. 350 of 1980*, Docket No. 99-059-BC issued on July 2, 1999. As you are aware, that order discussed the Rehabilitation Therapy Provider Class Plan filed by BCBSM on November 15, 1995. Thus, the Commissioner's comments in his order of July 2, 1999 relate to that Plan, not the Rehabilitation Therapy Provider Class Plan filed on February 15, 2000. Any comments which the Commissioner may have with regard to the Rehabilitation Therapy Provider Class Plan filed on February 15, 2000 will have to await the Commissioner's review of such Plan pursuant to the provisions of MCL 550.1509.

You also make note of the fact that you are not aware of the Rehabilitation Therapy Provider Class Plan filed on February 15, 2000 until I brought it to your attention in March of 2000. There does not appear to be any statutory requirement that the Commissioner or BCBSM give you notice that a new or revised Plan has been filed. In addition, there is no prohibition of which I am aware that precluded BCBSM from filing the Rehabilitation Therapy Provider Class Plan on February 15, 2000, while an appeal of the Commissioner's decision of July 2, 1999 was ongoing.

You raise an objection to the Rehabilitation Therapy Provider Class Plan filed on February 15, 2000 because it does not require physical therapists who work in hospitals to receive a Medicare supplier number. As you are aware, such physical therapists are not included in the Rehabilitation Therapy Provider Class Plan. Thus, the provisions of the Plan do not apply to them. Such physical therapists are employees of the hospital, which is subject to the Hospital Provider Class Plan filed by BCBSM, not the Rehabilitation Therapy Provider Class Plan.

In summary, I do not find that your letter raises any issues which constitute a violation of 1980 PA 350. By copy of this letter, I am forwarding your July 26, 2000 letter to the Commissioner of Insurance for his review and any action which he deems appropriate.

If you have any questions, please give me a call.

Very truly yours,

Larry F. Brya

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Assistant Attorney General
Insurance & Banking Division
(517) 373-1160

LFB:mm
c: Frank M. Fitzgerald (w/enc.)
Richard Mathews

JENNIFER MULHERN GRANHOLM
ATTORNEY GENERAL

November 3, 2000

SENT VIA FACSIMILE
& FIRST CLASS MAIL

.inda Fausey
:28 Walnut
.ansing, MI 48933

)ear Ms. Fausey:

I have been provided a copy of a letter dated October 20, 2000, which you sent o Frank Fitzgerald, Commissioner of the Office of Financial and Insurance Services ınd Richard Matthews, Legal Counsel to Blue Cross and Blue Shield of Michigan 'BCBSM). In that letter, you discussed certain issues which are presently in ıitigation. In the future, I request that you contact me with such concerns inasmuch ıs I represent Commissioner Fitzgerald in the litigation. I have also received by fax your November 2, 2000 letter addressed to the Commissioner with a copy to Mr. Mathews and to me. Following is my response to both your October 20, 2000 letter and your November 2, 2000 letter.

In the first several paragraphs of your first letter, you set forth certain actions which you believe BCBSM has taken with regard to Independent Physical Therapists and Outpatient Physical Therapy Facilities. You also comment on the Decision issued by Independent Hearing Officer John Foley in the matter entitled *P. T. Today, Inc. et al and Michigan Physical Therapy Association, Inc. v Commissioner of Insurance*, Docket No. 1999-3963 and 1999-3964 which is now on application for leave to appeal to the Court of Appeals, Docket No. 230016. As you know, Independent Hearing Officer Foley addressed the Rehabilitation Therapy Provider Class Plan as it existed in 1996 and 1997.

In the third full paragraph on page 2 of your letter, you state that because the Independent Hearing Officer ruled as he did, BCBSM may not require new contractual arrangements with Independent Physical Therapists or Outpatient Physical Therapy Facilities unless a new Provider Class Plan has been approved by the Independent Hearing Officer.

The Staff of the Commissioner will continue its review and investigation your ongoing allegations and you will be provided a further response as soon as possible.

If you have any further questions or concerns, please contact me.

Very truly yours,

Larry F. Brya
Assistant Attorney General
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If you have any questions, please give me a call.

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ATTORNEY GENERAL

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& FIRST CLASS MAIL

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In the third full paragraph on page 2 of your letter, you state that because the Independent Hearing Officer ruled as he did, BCBSM may not require new contractual arrangements with Independent Physical Therapists or Outpatient Physical Therapy Facilities unless a new Provider Class Plan has been approved by the Independent Hearing Officer.

It is my understanding that the actions which you allege BCBSM is taking against Independent Physical Therapists and Outpatient Physical Therapy Facilities are permitted under the Rehabilitation Therapy Provider Class Plan filed by BCBSM with the Commissioner in February of this year. As you know, that Plan was filed before the Independent Hearing Officer's Decision on August 30, 2000. As a result, the Independent Hearing Officer's Decision could not have precluded the filing of the revised Rehabilitation Therapy Provider Class Plan in February of this year. It is my further understanding that at the time of the the filing of the Rehabilitation Therapy Provider Class Plan in February of this year, there was no statutory prohibition forbidding BCBSM from filing such Plan and you have failed to cite any such prohibition.

In discussing this matter with Richard Matthews, it is my understanding that BCBSM will not terminate Participating Agreements that it has with an Independent Physical Therapist unless such Independent Physical Therapist fails to obtain a Medicare Supplier Number by December 31, 2000. At that time, if an Independent Physical Therapist has not filed such Medicare Supplier Number, BCBSM will provide a 60-day Notice of Termination under the terms of its Participating Agreement with such Independent Physical Therapist. My client has advised me that on October 26, 2000, the Insurance Division scheduled a meeting with representatives of BCBSM to discuss BCBSM's requirement that Independent Physical Therapists obtain a Medicare Supplier Number if they wish to continue participating with BCBSM. That meeting is presently scheduled for November 7, 2000. I hope to be able to provide you with the Commissioner's position on this matter soon after that meeting.

It is my further understanding that the Participating Agreement which BCBSM is requiring Outpatient Physical Therapy Facilities to sign is the new Participation Agreement attached to the Rehabilitation Therapy Provider Class Plan filed with the Commissioner in February of this year. Mr. Mathews further advised me that if an Outpatient Physical Therapy Facility does not sign the new Participating Agreement by November 29, 2000, their Participation Agreement will be terminated as of that date. According to Mr. Mathews, such Participation Agreement must be signed unequivocally and without any conditions. At this time, I am not aware of any statutory language which prohibits BCBSM from requiring Outpatient Physical Therapy Facilities to sign the new Participation Agreement if the Outpatient Physical Therapy Facility wishes to continue participating with BCBSM. Moreover, you have failed to cite any law to the contrary.

The Staff of the Commissioner will continue its review and investigation your ongoing allegations and you will be provided a further response as soon as possible.

If you have any further questions or concerns, please contact me.

Very truly yours,

Larry F. Brya
Assistant Attorney General
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